Program Application 1

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
MassHealth Premium Assistance Program
519 Somerville Ave #372
Somerville, MA 02143

FORM #1: Please fill out the information on this page and give your EMPLOYER FORM #2

Are you and/or your family covered by health insurance other than MassHealth? ❑ YES ❑ NO

If YES, which type: ❑ Employer ❑ COBRA

Have you and/or your family withdrawn from health insurance within the last six months? ❑ YES ❑ NO

If YES, Please name the plan? _____

End date & reason for withdrawal? _____

If you have health insurance please complete this section.

Policy Holder: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Telephone: _____ Work Telephone: _____

SSN: _____ DOB: _____

Medical Insurance Company: _____

Policy Number **(Mandatory)**: _____

Type of Coverage: ❑ Individual ❑ Dual ❑ Couple ❑ Family

Effective Date of Policy: _____ End Date: _____ Other: _____

List all members covered under the policy

Name	SSN	Date of Birth	Effective date

Program Application Form 2

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FORM #2 : Employee Name: SSN: XXX-XX-

Has employment terminated for the employee listed above? ❑ YES Date: _____ ❑ NO
(If YES, Please sign this form and return to the address listed above. If NO please continue.)

Employer Name: _____

Address: _____ Name of Contact: _____ Ext: _____

City: _____ State: _____ Zip: _____ Phone Number: _____

Federal Tax ID **(Mandatory)**: _____ Fax Number: _____

How many full time employees do you have? _____
Please continue to complete this form as it is important for our records!
Do you offer insurance to your employees? ❑ YES ❑ NO
How many medical health insurance plans are available to the employees? _____
Is the employee listed above enrolled on a health insurance plan? ❑ YES ❑ NO
If YES, which plan? _____
What is the type of plan? ❑ HMO ❑ PPO ❑ POS ❑ Major Medical ❑ Indemnity
What is the level of coverage for this plan? ❑ Individual ❑ Dual ❑ Couple ❑ Family
Annual Family Deductible? _____ Includes Pharmacy Coverage? ❑ YES ❑ NO
Effective Date of Policy _____ Policy Number **(Mandatory)** _____
If NO, does this employee have access to purchasing a family plan? ❑ YES ❑ NO

Has the employee listed above withdrawn from a family health plan within the last six months? ❑ YES ❑ NO
If YES, which plan? _____ & Termination Date: _____

*Please complete the graph below using family plan rates for each health insurance plan offered. Also a **Summary of Benefits** for the health insurance plan the applicant is either enrolled in or has access to will be needed.*

	Health Plan #1	Health Plan #2	Health Plan #3	Health Plan #4
NAME AND TYPE OF PLAN:				
LEVEL OF COVERAGE OFFERED	❑ Individual ❑ Dual ❑ Couple ❑ Family	❑ Individual ❑ Dual ❑ Couple ❑ Family	❑ Individual ❑ Dual ❑ Couple ❑ Family	❑ Individual ❑ Dual ❑ Couple ❑ Family
Family Coverage Total Monthly Premium				
Employer Contribution				
Employee Pays Monthly				
Group #				
Open Enrollment Dates				

Signature Of Person Completing Form _____ Date : _____

Compliance Form

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MassHealth

Premium Assistance Review Form

Please review the information below to ensure it is accurate. If the information is not correct, please write in the correct information so we may update our files. If any of the health insurance information for this individual is not already filled in, please report the correct information

	INFORMATION ON FILE	CURRENT INFORMATION - (IF DIFFERENT)
Policy Holder/Member		
Employer Name		
Employer's Human Resource Address		
Insurance Company		
Plan Name		
Type of Plan		❑ HMO ❑ PPO ❑ POS ❑ EPO ❑ Major Medical ❑ Indemnity
Plan Tier		❑ Individual ❑ Dual ❑ Couple ❑ Family
Policy Number		
Group Number		
Policy Start Date: (MM/DD/YYYY)		
Total Monthly Plan Amount		
Monthly Employer Contribution		
Monthly Employee Contribution		
Rate Year (dates premium rates are effective):		
Individuals covered by Policy (MassHealth ID)		